IN THE SUPREME COURT OF MISSOURI

Appeal No. SC 92700

Alice Roberts, et al.,

Appellants,

vs.

BJC Health System d/b/a BJC Healthcare, et al.,

Respondents.

SUBSTITUTE REPLY BRIEF OF APPELLANTS ALICE ROBERTS, KEVIN HALES, AND TIM AND CHRISTY MILLSAP

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INTRODUCTION

For a number of years, Appellants and Respondents have been arguing about whether healthcare consumers who incurred charges when they entered Respondent entity and institutions as patients, may pursue causes of action for overcharges for their care. The Respondents contend that the Appellants' insurance carriers or their employers' workmen's compensation carriers may have claims, but not the Appellants. Appellants have consistently declared that under Missouri law, they are the parties with the legally protectable "ownership" interest in the litigation.

Appellants will not use the opportunity of this reply to re-argue the meaning and precedential value of each case cited in their Substitute Brief. Instead, Appellants will focus upon responding to several themes which seem to recur throughout, even if not in all, Respondents' Substitute Briefs.

ARGUMENT

Respondents' early procedural machinations have no substantive carry-over to the issues before this Court.

To the extent the Respondents invite this Court to give any weight to the decision of either the United States District Court for the Eastern District of Missouri or the Eighth Circuit Court of Appeals, *see* Substitute Brief of Missouri Baptist at pp. 12, 26; Substitute Brief of Sisters of Mercy at p. 5; Substitute Brief of St. John's at pp. 8-9, 13-14, this Court should decline the invitation. Following the removal of Appellants' state court

petition to the federal court on the grounds that ERISA preempted Appellants' claims,[1] the Respondents moved for dismissal of the action on a number of different grounds. (L.F. 585). The federal court considered only one of the issues raised by Respondents, that of Article III standing. The District Court viewed the issue solely as a matter of federal law, defining the question before it to be whether Appellants' pleading established that Appellants had standing under Article III of the United States constitution so as to confer subject-matter jurisdiction upon the federal district court. (L.F. 585-87). The court concluded that the federal court lacked subject-matter jurisdiction because Appellants lacked Article III standing. (L.F. 590). The court initially dismissed the action (L.F. 591), but subsequently realized that its finding required a remand to state court rather than dismissal (L.F. 593), a realization the Eighth Circuit Court of Appeals upheld in the course of dismissing the appeal brought by the *Respondents* of the District Court's decision to remand rather than dismiss. *Roberts v. BJC Health System*, 452 F.3d 737 (8th Cir. 2006).

The decisions of neither of these federal courts have any precedential value whatsoever in the case now before this Court. As stated above, the District Court

[1]Appellants believed, and continue to believe, that ERISA does not preempt their claims and that the action never belonged in federal court. Following removal, Appellants moved the District Court to remand the action to state court. (Respondents' Supplemental Legal File ("R.S.L.F.") 185-190). The District Court disposed of the case on different grounds and never decided the ERISA preemption issue. (L.F. 591-92).

regarded the question before it to be one strictly of federal law. Indeed, in its Memorandum and Order, the District court failed to cite a single case decided by a Missouri state court. (L.F. 582-92). The case now before this Court presents important questions of Missouri law, such as whether Appellants constitute real parties in interest and whether Appellants incurred damages, as well as the effect of the collateral source rule upon these issues. Other than a fleeting dismissal, in a footnote, of the collateral source rule (L.F. 590), the District Court considered none of these issues, and its thoughts on this case have no relevance to the case at bar.[2]

The Eighth Circuit's opinion, dismissing Respondents' appeal of the District Court's remand order, likewise has absolutely no relevance to the case at bar. In its brief

[2]In its brief to this Court, Sisters of Mercy makes the absurd statement that "Appellants have never disagreed with, challenged, complained about, or sought to distinguish the federal court's decision in this case." Substitute Brief of Sisters of Mercy at p. 5. On the contrary, when the case was before the federal court, Appellants opposed Respondents' Motions to Dismiss. When the federal court initially ordered the action dismissed, Appellants filed a motion pointing out that the federal court's only choice, based on its view of the Article III standing matter, was to remand to state court. (R.S.L.F. 216-219). Once the federal court remanded to state court, Appellants no longer had any need to "disagree with, challenge, complain about or distinguish" the federal decision, since that decision no longer had any relevance to or bearing upon the issues subsequently raised during the course of the state court proceedings.

to this Court, St. John's badly mischaracterizes the Eighth Circuit's position by stating, "The Eighth Circuit agreed with the District Court that there was no jurisdiction, ruling that Appellants 'lacked standing because they had not sustained an injury in fact.'" Substitute Brief of St. John's at p. 8 (quoting *Roberts*, 452 F.3d at 738). The Eighth Circuit, however, did no such thing. The Eighth Circuit concluded that federal law prohibits appellate review of a District Court's remand order and, therefore, dismissed the appeal. *See Roberts*, 452 F.3d at 738. Contrary to the assertion of St. John's, the Eighth Circuit never agreed or disagreed with the District Court as to whether Appellants sustained an injury in fact, because the Eighth Circuit never reached the question. The language from the Eighth Circuit's opinion, quoted by St. John's, merely described what the District Court had concluded, nothing more.

This Court should also not be led astray by the Respondents' incorrect assertions that Appellants have substantively changed their definition of the proposed class or that Appellants are now asserting a position different from that taken before the federal court. *See* Substitute Brief of BJC at p. 25; Substitute Brief of Sisters of Mercy at pp. 1, 2, 5, 6; Substitute Brief of St. John's at pp. 6, 7, 21-22. When Appellants initially filed suit in the Circuit Court for the City of St. Louis, they defined the proposed class to include "[a]ll persons who, during the Relevant Period . . . ." (R.S.L.F. 31-32 (paragraph 90 of the

Complaint)).[3] After removal of the initial petition to the federal court, Appellants voluntarily dismissed the action and then filed a revised petition in the Circuit Court for the City of St. Louis. (R.S.L.F. 111-12, 113-184). Appellants did so for two reasons. First, the description in the revised petition of the proposed class clarified what Appellants had intended all along: the proposed class included only "natural persons" and not insurance companies. (R.S.L.F. 148). Second, the revised petition added as named plaintiffs Christy and Tim Millsap and set forth allegations concerning the treatment of their daughter, (R.S.L.F. 123, 145-47); the named plaintiffs in the original petition included only Alice Roberts and Kevin Hales, and the original petition included no allegations concerning the Millsaps' daughter. (R.S.L.F. 9-56). Contrary to Respondents' insinuations, Appellants have, from the beginning, consistently defined their proposed class.

Moreover, Appellants have not taken different positions in this Court and in the federal court. Appellants consistently stated to the federal court that Appellants were not

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[3]Appellants acknowledge that paragraph 89 of the Complaint refers to "all persons or entities who are members of the Class during the Relevant Period . . . ." (R.S.L.F. 31). As is abundantly clear from the arguments Appellants made in the federal court in the course of seeking remand of the case to the state court, at no time did Appellants ever intend that the proposed class should include insurance companies. *See* Plaintiffs' Motion to Remand (R.S.L.F. 79-83) and Memorandum of Points and Authorities in Support of Plaintiffs' Motion to Remand (R.S.L.F. 84-103).

suing to recover benefits under an ERISA plan and that Appellants were not suing in their capacities as ERISA plan participants or beneficiaries. (R.S.L.F. 189, 196, 199-200). Appellants have said nothing in this Court to the contrary. Appellants have recognized that, if they recover in this action from Respondents, then those insurance companies that paid Appellants' medical bills (pursuant to a class member's own health insurance policy or a worker's compensation policy) might assert a subrogation right to some or all of Appellants' recovery. That possibility in no way changes the essential nature of this action: Appellants were patients and/or consumers of medical services; Appellants were the individuals to whom the providers of those services looked for payment if Appellants either lacked insurance or if Appellants' insurance declined to pay; and Appellants allege that the providers of the services overcharged them for the services and should be held accountable for the excessive charges.

The trial court erred by equating "damages" with out-of-pocket expenses.

The healthcare provider Respondents have continued to rail at the idea that healthcare consumers who have been overcharged and defrauded may assert claims against the perpetrators when insurance companies, on behalf of those consumers, have paid the bills. In order to expose the fallacy of that argument, it is essential to focus on the nature of the relationships among the parties. The focal point is the linkage between the patient and the healthcare provider. In return for medical services provided to the patient, the patient agrees "as patient or guarantor, to pay the hospital and physicians for all services ordered by the attending physician, the patient and the patient's family." *See*, *e.g.*, Appendix to Appellants' Substitute Brief, A9, ¶ 7 (Contract between Missouri

Baptist Medical Center and Kevin Hales). In the same contract, the patient or patient's representative "authorize[s] direct payment" to the hospital and physicians of all insurance benefits applicable to the hospitalization which become due and payable to the patient. *See* Appendix to Appellants' Substitute Brief, A9, ¶ 8. Likewise, the ethical duties of the healthcare professionals arise out of the patient-provider relationship[4].

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[4] The healthcare provider community well understands the nature of the relationships. "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." AMA Principles of Medical Ethics, Principle VIII.

> "Providers" are the medical doctors that render health care to patients. "Payors" refers to the entities that make payments for medical care on behalf of the members of their coverage plans. Included within the group of "payors" are government–financed entities such as Medicare and Medicaid; self-paying individuals who have no health insurance coverage; and the commercial payors such as Blue Cross/Blue Shield, as well as independent provider networks who organize providers and make them available to insurance carriers, self-funded or insured groups, and employers.

Woman's Clinic, Inc. v. St. John's Health System, Inc., 252 F.Supp.2d 857, 862 (W.D. Mo. 2002) (Network prevailed on Clinic's allegations of antitrust claims under the Sherman Act and Missouri law).

Clearly, the relationship of the insurance companies to the healthcare providers is derivative from that of the patient-provider relationship. In its assertion that Appellants were never damaged, St. John's states that Appellants "cannot claim a cognizable injury merely because their insurance companies, which were not parties to the lawsuit, might have been overbilled for medical care provided to Appellants." Substitute Brief of St. John's at pp. 12-13. That assertion flies in the face of the very definition of "payor" as well as the terms of the hospital's contract with patients. In reality, it is the patient who is billed, with the insurance company acting as the pay agent on behalf of a member of their coverage plan. If an insurance company suffers a monetary loss as a result of paying provider overcharges, subrogation is the means by which it may be rendered whole. *See, Kroeker v. State Farm*, 466 S.W.2d 105, 110 (Mo. Ct. App. 1971) (absent assignment, insurer is subrogated to rights of injured person against wrongdoer or others who are primarily responsible for wrong or default); *Gaunt v. State Farm Mut. Auto. Ins. Co.*, 24 S.W.3d 130, 134 (Mo. Ct. App. 2000) (under collateral source rule, whether plaintiff has insurance coverage that pays his or her damages is irrelevant); *Lockwood v. Schreimann*, 933 S.W.2d 856, 862 (Mo. Ct. App. 1996) (fact of worker's compensation payment with consequent *pro tanto* subrogation to the employer is neither a defense to the action nor will it serve to reduce damages recoverable for loss).

Cases invoked by one of the Respondents, involving particular federal statutes, *see* Substitute Brief of RMA at pp. 6-7, 12, should carry no persuasive force with this Court. In *Securities and Exchange Commission v. Comserv Corp.*, 908 F.2d 1407 (8th Cir. 1990), the S.E.C. had sued a corporate officer for alleged violations of the federal securities

laws. The District Court granted the officer's motion to dismiss at the close of the SEC's case in chief. *Comserv*, 908 F. 2d at 1409-10. The officer then filed an application seeking attorneys' fees and expenses pursuant to the Equal Access to Justice Act ("EAJA"), 5 U.S.C. § 504, 28 U.S.C. § 2412. *Id.* The S.E.C. opposed the motion on multiple grounds, including its contention that the corporate officer had not incurred any legal fees or expenses because those costs were paid by an insurance company pursuant to a policy held by the officer's corporate employer. *Id.* at 1411.

The Eighth Circuit held that the officer had not incurred attorneys' fees under EAJA, but it based its holding primarily upon the intent of Congress when it enacted EAJA. According to the Eighth Circuit, Congress adopted EAJA to overcome the deterrent effect of attorneys' fees in defending against unreasonable government action. *Id.* at 1415. Because the corporate officer in *Comserv* "was able to pursue his defense in the SEC action secure in the knowledge that he would incur no legal liability for attorneys' fees," *id.* at 1414, the Eighth Circuit concluded that awarding fees to the officer under these circumstances would not promote the policy underlying EAJA. *Id.* at 1415-16.

This case, therefore, has no applicability to the case at bar. If this Court even agrees that the Eighth Circuit reached the correct conclusion, the Eighth Circuit did so in the context of construing a unique and narrow federal statute, designed for a specific purpose and to promote a specific public policy, none of which are present in the instant case.

Similarly, while RMA labels as "instructive" the opinion in *Steele v. Hospital Corporation of America*, 36 F.3d 69 (9th Cir. 1994), *see* Substitute Brief of RMA at p. 6, that case has no applicability at all to the present appeal. In *Steele*, the Ninth Circuit affirmed the District Court's dismissal of a civil suit brought under the federal Racketeer Influenced and Corrupt Organization Act ("RICO"), 18 U.S.C. §§ 1961-68. In that case patients and their parents alleged that a doctor and a hospital had conspired to bill insurance companies for services that were not provided or were inappropriate. *Steele*, 36 F.3d at 70. The civil RICO statute, however, contains a distinct standing provision, which requires that a plaintiff prove that he or she was "injured in his business or property by reason of a violation of" RICO. *Id.* (quoting 18 U.S.C. § 1964(c)). The Court noted that "[t]his limitation to a person 'injured in his business or property' has a 'restrictive significance,' . . . which helps to assure that RICO is not expanded to provide 'a federal cause of action and treble damages to every tort plaintiff.'" *Id.* at 70 (internal citations omitted). Accordingly, the *Steele* opinion is limited to the federal RICO context, and provides no guidance to this Court in determining the issues presented in the case at bar.

Also inapt are cases cited by Respondent St. John's (Substitute Brief of St. John's at p. 31) that depend on statutory interpretation to analyze both standing and damages as components of causes of action. Federal precedent in ERISA cases does not act to preempt Appellants' claims. For example, the case of *Garofalo v. Empire Blue Cross & Blue Shield*, 67 F.Supp.2d 343 (S.D.N.Y. 1999), involved a plaintiff arguing she still had

standing to sue under the New York "collateral source" rule when the doctrine is inapplicable in that ERISA case.

The Appellants constitute the real parties in interest.

The party with the bare legal title to a claim is the real party in interest. In situations when an insurer pays a loss, its becoming the real party in interest depends on whether the insured has assigned the underlying claim to it. None of the Appellants have assigned their claims. When an insured does not assign his or her claim, the insured retains title to the action. *See*, Mo. Rev. Stat. § 507.010 (2009) (prosecution in name of real party in interest); Mo.S.Ct.R. 52.01; *Protection Sprinkler Co. v. Lou Charno Studio*, 888 S.W.2d 422, 424 (Mo. Ct. App. 1994). Likewise, regardless of the employer's right of subrogation under Section 287.150, the employee remains the real party in interest and may bring a suit against a third-party tortfeasor for all of his damages. *Kinney v. Schneider Natl. Carriers, Inc.*, 200 S.W.3d 607, 613 (Mo. Ct. App. 2006) (employer did not have right to intervene in employee's suit against third party tortfeasors as intervention was not necessary to preserve employer's workers' compensation subrogation claim; fact that employer was not a party to employee's suit against third-party tortfeasors did not forfeit or limit employer's right to seek reimbursement for workers' compensation benefits paid to employee.)

Respondent's argument relating to Appellants' standing is "less than compelling" as "[s]tanding to sue is an interest in the subject matter of the suit, which if valid, gives that person a right to relief." *State ex rel. Twenty-Second Judicial Circuit v. Jones*, 823 S.W.2d 471, 474-75 (Mo. banc 1992). The party asserting standing must allege a

personal stake in the outcome of the controversy in order to warrant invocation of the court's jurisdiction and to justify exercise of the court's remedial powers on the party's behalf. In the case at bar, Appellants have a "personal stake" as they were victims of a scheme to overcharge for medical services. *See Harrison v. Monroe County*, 716 S.W.2d 263, 266 (Mo. banc 1986).

Respondents cannot abrogate the applicability of the collateral source to this case based on Appellants not carrying "overbilling insurance."

The Respondents have joined as a chorus to sound the refrain that Appellants should not be heard to argue the applicability of the collateral source rule because they are complaining about overcharges and none of them had "'medical overcharging insurance' that paid to mitigate their losses arising from inflated bills." *See*, Substitute Brief of RMA at p. 16; *see also* Substitute Brief of Missouri Baptist at p. 22 (purpose of Hales' employer's worker's compensation insurance policy was to insure against cost of Hales' medical treatment, not to insure against potential overbilling); Substitute Brief of BJC Health System at p. 51 (insurance money paid by worker's compensation carrier was not paid to cover losses due to alleged overbilling, but rather to cover healthcare for work related physical injury); Substitute Brief of RMA at p. 5 (because Appellants did not obtain and/or pay for insurance against allegedly inflated bills, they have no claim against entities that supposedly issued the inflated charges); Substitute Brief of St. John's at p. 21 (Appellants did not have insurance that covered them for a "loss" sustained by reason of being overcharged). In an effort to nullify the applicability of the collateral source rule,

Respondents have built a straw person, if you will, by creating the argument that none of the Appellants carried overcharge insurance.

Appellants had health insurance. Charges for healthcare cannot be split between the legitimate charge for care and the overcharge resulting from upcoding. While the authorized charge versus the impermissible upcoded charge may well have an impact on the amount of damages at issue, it does not affect the fact that by incurring charges, Appellants suffered damages.

In 1960, the collateral source rule was established in Missouri. *Kickham v. Carter*, 335 S.W.2d 83 (Mo. 1960). The collateral source rule is not one single rule, but a combination of different rationales applied to a number of situations to determine whether mitigation of damages should be precluded from admission into evidence. *Washington v. Barnes Hosp.*, 897 S.W.2d 611, 619 (Mo. banc 1995). One theory behind the collateral source rule is that a wrongdoer should not enjoy the benefit of reduced liability by showing that the plaintiff has already been compensated for the loss from a collateral source, independent of the wrongdoer. *Id*. at 619 (citing *Collier v. Roth*, 434 S.W.2d 502, 506-07 (Mo. 1968)).

"Medical insurance purchased by a plaintiff and governmental benefits contingent upon a plaintiff's financial need or special status, such a [sic] Medicare and Medicaid, are independent sources that are subject to the collateral source rule…The rationale for such application of the collateral source rule is that plaintiffs who contract for insurance or other benefits with funds they could have used for other purposes are entitled to the benefit of their bargain." *Porter v. Toys 'R' Us-Delaware, Inc.*, 152 S.W.3d 310, 320

(Mo. Ct. App. 2004) (internal citations omitted). In discussing the collateral source rule, the *Porter* court drew heavily upon *Washington v. Barnes Hospital*. Appellants have cited extensively from *Washington v. Barnes* because of this Court's review of the multiple rationales used to support application of the collateral source rule. Equally important to note, however, are the numerous Missouri cases cited by this Court to illustrate the almost universal application of the collateral source rule to prevent defendants from informing the fact-finder of coverage and payments, *e.g.*, *Blessing v. Boy Scouts of America*, 608 S.W.2d 484, 488-89 (Mo. Ct. App. 1980) (insurance policies contracted for and paid for by plaintiffs); *Douthet v. State Farm Mut. Auto Ins. Co.*, 546 S.W.2d 156, 159-60 (Mo. banc 1977) (worker's compensation benefits); *Leake v. Burlington Northern R. Co.*, 892 S.W.2d 359, 363 (Mo. Ct. App. 1995) (disability pension benefits); *Mateer v. Union Pacific Systems*, 873 S.W.2d 239, 245 (Mo. Ct. App. 1993) (retirement benefits); *Beck v. Edison Bros. Stores, Inc.*, 657 S.W.2d 326, 330-31 (Mo. Ct. App. 1983) (employer's medical plan); *Siemes v. Englehart*, 346 S.W.2d 560, 563-64 (Mo. Ct. App. 1961) (sick leave); *Cornelius v. Gipe*, 625 S.W.2d 880, 882 (Mo. Ct. App. 1981) (dicta in case, found social security, medicare and medicaid to be collateral sources); *Hood v. Heppler*, 503 S.W.2d 452, 454-55 (Mo. Ct. App. 1973) (veterans' benefits). *Washington v. Barnes Hospital*, 897 S.W.2d at 619-20.

Some Respondents argue that Appellants Roberts and Hales did not "bargain" with their employers for the benefit of worker's compensation. Regardless, whether a benefit is bargained for or not is not a criterion of analyzing the applicability of the collateral source rule. *See, e.g., Aaron v. Johnston*, 794 S.W.2d 724, 726-27 (Mo. Ct.

App. 1990) (gratuitous continuation of wages by plaintiff's employer would be a collateral source) (also cited in *Washington v. Barnes Hospital*). Moreover, Appellants Roberts and Hales "paid" for their workers' compensation benefits with the labor they provided to their employers.

Respondent BJC Health System uses the case of *Farmer-Cummings v. Personnel Pool of Platte County*, 110 S.W.3d 818 (Mo. banc 2003) to illustrate the "limits" of the collateral source rule. The case is readily distinguishable. In *Farmer-Cummings*, statutory construction of Mo. Rev. Stat. § 287.140 was at issue. The holding that medical bills that had been written off by the provider did not constitute "fees and charges" under § 287.140 is not germane to whether the collateral source rule applies to the instant matter. *See Lampe v. Taylor*, 338 S.W.3d 350, 360-61 (Mo. Ct. App. 2011) (Medicaid is collateral source that should not be disclosed to the jury; prohibition includes disclosure to jury of write-offs health care providers are required to make because they accept Medicaid payments).

Simply put, under the collateral source rule, a wrongdoer is not entitled to have the damages for which it is liable reduced by proving that a plaintiff has received, or will receive, compensation or indemnity for the loss from a collateral source. Thus, Respondents cannot absolve themselves of liability because Appellants had bills paid on their behalf by private insurance and worker's compensation carriers.

Moreover, the circuit court relied on evidence that would be inadmissible at trial to conclude that Appellants did not suffer damages. Thereby, the court erred. *See generally* Mo.R.Civ.P. 74.04(e); *United Petroleum Service, Inc. v. Piatchek*, 218 S.W.3d 477, 481

(Mo. Ct. App. 2007) (hearsay statements cannot be considered in ruling on propriety of summary judgment; only evidence that is admissible at trial can be used to sustain or avoid summary judgment); *American Family Mut. Ins. Co. v. Lacy*, 825 S.W.2d 306, 311 (Mo. Ct. App. 1992) (statements of officers were opinions, conclusions and speculations neither admissible or usable at trial and, thus, could not be used to sustain or avoid summary judgment).

Appellants' expert testified as to the existence of damages.

It is elemental that this Court must review the record in the light most favorable to the party against whom summary judgment was entered. *Stanley v. City of Independence*, 995 S.W.2d 485, 486 (Mo. 1999), citing *ITT Commercial Fin. Corp. v. Mid–Am. Marine Supply Corp.*, 854 S.W.2d 371, 376 (Mo. banc 1993). Respondents' one-sided and selective recitations of the import of the testimony of Appellants' expert, Raymond Janevicius, M.D., disregard this precept. While an advocate may be expected to either cite or quote extensively from those portions of Dr. Janevicius' deposition testimony that favor the Respondents' position, Respondents omit any of Dr. Janevicius' testimony favorable to the Appellants. Despite Appellants' citation to this testimony in their Substitute Brief, Respondents blithely ignore that testimony and proceed to enunciate the oft-repeated "company line" on the matter – that Dr. Janevicius "testified that he did not have any opinions whether any of the Plaintiffs, including Mr. Hales, had suffered any financial damages as a result of the alleged overbilling for health care services."

(Substitute Brief of BJC at p. 5).[5] Only one of the Respondents, RMA, strays from the beaten path, after reciting the familiar refrain. RMA acknowledges that Dr. Janevicius' testimony indicates "that wrong was done and harm was suffered" [without allegedly showing that the Appellants suffered the harm]. (Substitute Brief of RMA at p. 14).[6]

In fact, Dr. Janevicius' testimony did state that inappropriate overcharges were made due to Respondents' miscoding by unbundling, upcoding and fabrication of procedures. Dr. Janevicius testified:

> Q. In other words, if you were going to give a summary, how would you title it?
>
> A. Alice Roberts, a summary of what I found was up-coding, unbundling and an exaggeration of one of the procedures as it was coded. Brittany

[5] See also, Substitute Brief of Missouri Baptist at p. 5 (nearly verbatim recitation); Substitute Brief of Reconstructive and Microsurgery Associates, Inc. ("RMA") at p. 2 (nearly verbatim recitation); Substitute Brief of Sisters of Mercy Health System at p. 4 (nearly verbatim recitation); Substitute Brief of St. John's at p. 2 (paraphrased without citation to record).

[6] RMA argues that Appellants purportedly concede that Dr. Janevicius' testimony is not helpful because the Appellants purportedly omitted the testimony from the argument portion of Appellants' Brief. (Substitute Brief of RMA at p. 13). The matter is, in fact, referenced within Appellants' argument. (Substitute Brief of Appellants at p. 15).

> Millsap, there was unbundling of procedures and an exaggeration of one of the procedures. Let me not use the word exaggeration. Let me use up-coding rather than exaggeration, up-coding of one of the procedures.
>
> Q. So Millsap was up-coding?
>
> A. Millsap was up-coding and unbundling. And then Kevin Hales, there was unbundling, and there was a fabrication of one of the procedures as indicated in the operative report.

(LF 230; Janevicius Dep. 39-40; Reply Appendix p. A3). Dr. Janevicius also testified that this miscoding resulted in "additional" or "extra" charges that were inappropriate. (LF 237-239; Janevicius Dep. 66, 71-74; Reply Appendix p. A6-A8). For example, Dr. Janevicius testified with respect to Appellant Alice Robert's charges as follows:

> Q. My question is if the bill for Alice Roberts both of her carpal tunnels indicates that there was an additional charge for the fasciotomy, do you have any opinion as to whether that was appropriate or any opinion about that bill?
>
> [objection to form of question]
>
> THE WITNESS: That extra charge would not be

appropriate in either of these cases.

(LF 237; Janevicius Dep. 66; Reply Appendix p. A6).

Because the circuit court's Order of November 8, 2008, was limited to the issue of standing and injury in fact, Dr. Janevicius was asked only if damages existed; he was not asked to quantify any damage amount at this stage. Appellants' expert's testimony plainly establishes the existence of damages, though, concededly, not the amount of those damages. The testimony of Appellants' expert cited by the Respondents, that he had no opinion of "damages," came in response to questions from Respondents' counsel as to the existence of "damages," which was explained to Dr. Janevicius, upon his request for clarification, as "a term of art that attorneys use." (LF 230; Janevicius Dep. 40-41; Reply Appendix p. A3). The unmistakable essence of Dr. Janevicius' testimony is that the Appellants were inappropriately overcharged for the medical services they received, *i.e.*, the Appellants were damaged.

The Workers' Compensation Law does not exclude Appellant workers from pursuing damages.

Contractually, both Appellants Roberts and Hales incurred [potential] liability despite the fact that neither had to pay out-of-pocket expenses for the care they each required and received as a result of their respective work-related condition or injury. *See*, Appendix to Appellants' Substitute Brief, A11, ¶ "FINANCIAL RESPONSIBILITY"; A9, ¶ 7. Contrary to BJC's citation (Substitute Brief of BJC at p. 31), the subrogation contemplated by the statutory scheme does not qualify the word "injury" with "physical." Rather, where a third party is liable to the employee for injury, the employer is

subrogated to the right of the employee against such third party. Mo. Rev. Stat. § 287.150.

Furthermore, counter to BJC's assertion (Substitute Brief of BJC at p. 28), the statutory schemata does not "completely insulate" the employee-patient from a healthcare provider's pursuit of payment. Respondent BJC cites section 287.140(5) as the proverbial teflon coating for employees. Yet, another subsection in the same statute allows for direct action by the provider against the employee, section 287.140(13)(3), when an injury is found to be noncompensable under the chapter. Employees may remain liable for medical care they seek as a result of workplace injury. Thus, employees may bear financial obligations to healthcare providers.

The circumstances in *Freeman Health System v. Wass* are not those in the instant matter.

Respondents contend that the case of *Freeman Health System v. Wass*, 124 S.W.3d 504 (Mo. Ct. App. 2004) is analogous (Substitute Brief of RMA at p. 9) or "remarkably similar to the instant one" (Substitute Brief of Missouri Baptist at p. 29; Substitute Brief of St. John's at p. 16). Respondents' argument harkens back to their theory of equating "ascertainable loss" with proof of actual out-of-pocket expenses. First, it bears repetition that in response to a bill for services provided to Wass, Freeman Health System received *no* payment -- not from Wass, not from an insurance company on his behalf, not from anyone else. In the case at bar, in contrast, each Respondent-provider received payment by an insurer on behalf of the Appellant-patient treated. The key to the *Freeman Health System* case was that no money changed hands, as it were. Generally, the MMPA and

similar consumer protection laws cannot be utilized when the remedy being sought is for possible future expenses not yet incurred or claiming an ascertainable loss by virtue of a bill [*e.g.*, for medication] that was never paid. *See generally*, Mary Dee Pridgen, *Consumer Protection and the Law § 5:10* (October 2011). Here, Respondents' inflated bills were paid.

CONCLUSION

For the foregoing reasons, this Court should reverse the circuit court's grant of summary judgment in favor of Respondents and should remand the case to the circuit court for further proceedings.

Respectfully submitted,

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